Publix Specialty Pharmacy #3213

DERMATOLOGY (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________ Patient's Last Name: ______________________

Date of Birth: _____/_____/________ Male Female Caregiver Name: ______________________

Address: ______________________ City: __________ State: ________ Zip: __________

Primary Phone Number: (_____) ______________ Alt. Phone Number: (_____) ______________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code(s): ____________ Diagnosis: ☐ Psoriasis (PsO) ☐ Psoriatic Arthritis (PsA) ☐ Hidradenitis Suppurativa (HS)

Treatment status: ☐ New to therapy ☐ Other: ______________ If, HS, Hurley Stage: __________

☐ Continuation of therapy, start date: ______/______/________ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in Weight: ______ ☐ kg ☐ lb

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/______/_________ BSA affected: ____________ %

Allergies: ☐ NKDA ☐ Other: ______________________

Prior therapy, treatment dates, and reason for discontinuation: ______________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Cimzia (certolizumab)	☐ Starter Kit: 6 x 200 mg/mL PFS ☐ 200 mg vial	Initial Dose: Inject 400 mg SC on days 1, 15 and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: ☐ Inject 400 mg SC every other week ☐ Inject 400 mg SC every 4 weeks ☐ Inject 200 mg SC every other week	☐ 28 days ☐ 84 days	_______
☐ Cosentyx (secukinumab)	☐ 150 mg/mL Sensoready pen ☐ 150 mg/mL PFS	Initial Dose: ☐ Inject 300 mg SC every week for 5 weeks ☐ Inject 150 mg SC every week for 5 weeks	4 doses	0
		Maintenance Dose: ☐ Inject 300 mg SC every 4 weeks ☐ Inject 150 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Enbrel (etanercept)	☐ 50 mg/mL Mini cartridge ☐ 50 mg/mL SureClick pen ☐ 50 mg/mL PFS ☐ 25 mg/0.5 mL PFS	Initial Dose: ☐ Inject 50 mg SC twice a week (3-4 days apart) for 12 weeks	84 days	0
		Maintenance Dose: ☐ Inject 50 mg SC every week ☐ Inject 25 mg SC TWICE a week (3-4 days apart)	☐ 28 days ☐ 84 days	_______

Prescriber Information [Ship to prescriber: Never Always First fill only Appointment date: ___/___/_____

Name: ______________________ DEA# ____________ NPI # ______________

Supervising Physician: Not Applicable ______________ Supervising Physician NPI # ______________

Address: ______________________ City: __________ State: ________ Zip: __________

Office Phone Number: (_____) __________ Fax Number: (_____) __________ Office Contact: ______________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature:
(stamps not accepted)

______________________ ______________________
☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Publix Specialty Pharmacy #3213

DERMATOLOGY (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________________ Patient's Last Name: ____

Date of Birth: _____/_____/________ Male Female Caregiver Name:____

Address: ____ City: __________________ State: ___________ Zip: ______________

Primary Phone Number: (_____) _____________________________ Alt. Phone Number: (_____) ____________________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code(s): ________________ Diagnosis: ☐ Psoriasis (PsO) ☐ Psoriatic Arthritis (PsA) ☐ Hidradenitis Suppurativa (HS)

Treatment status: ☐ New to therapy ☐ Other: _____________________________ If, HS, Hurley Stage: ______________

☐ Continuation of therapy, start date: ______/______/________ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in Weight: ______ ☐ kg ☐ lb

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/______/_________ BSA affected: ________________ %

Allergies: ☐ NKDA ☐ Other: ____

Prior therapy, treatment dates, and reason for discontinuation: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Humira (adalimumab)	☐ Psoriasis Starter Kit (citrate-free) ☐ Psoriasis Starter Kit	Initial Dose: Inject 80 mg SC on day 1, then 40 mg every other week starting on day 8	35 days (1 kit)	0
	☐ HS Starter Kit (citrate-free) ☐ HS Starter Kit	Initial Dose: ☐ Inject 160 mg SC on day 1, then 80 mg on day 15 ☐ Inject 80 mg SC on days 1, 2, and 15	28 days (1 kit)	0
	40 mg/0.4 mL pen (citrate-free) 40 mg/0.8 mL pen 40 mg/0.4 mL PFS (citrate-free) 40 mg/0.8 mL PFS 80 mg/0.8 mL pen (citrate-free)	Maintenance Dose: (starting on day 29) ☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other week	☐ 28 days ☐ 84 days	_______
☐ Ilumya (tildrakizumab)	100 mg/mL PFS	Initial Dose: Inject 100 mg SC on day 1	1 dose	0
		Maintenance Dose: Inject 100 mg SC every 12 weeks starting on day 29	84 days	_______
☐ Orencia (abatacept) Pt wt: _______	☐ 125 mg/mL ClickJect pen ☐ 125 mg/mL PFS	Inject 125 mg SC every week	☐ 28 days ☐ 84 days	_______
	☐ <60kg: 500 mg (2 vials) ☐ 60-100kg: 750 mg (3 vials) ☐ >100kg: 1000 mg (4 vials)	Infuse one dose IV on weeks 0, 2, 4, then every 4 weeks	1 dose	_______

Prescriber Information [Ship to prescriber: Never Always First fill only Appointment date: ___/___/_____

Name: ____ DEA# ____________________ NPI # ___________________________

Supervising Physician: Not Applicable ________________________________ Supervising Physician NPI # ______________________

Address: ____ City: ___________________ State: ___________ Zip: ______________

Office Phone Number: (_____) _________________ Fax Number: (_____) __________ Office Contact: _____________________________

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DERMATOLOGY (FORM C)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________ Patient's Last Name: ______________________

Date of Birth: _____/_____/________ Male Female Caregiver Name:______________________

Address: ______________________ City: __________________ State: ___________ Zip: ______________

Primary Phone Number: (_____) ______________________ Alt. Phone Number: (_____) ______________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code(s): ________________ Diagnosis: ☐ Psoriasis (PsO) ☐ Psoriatic Arthritis (PsA) ☐ Hidradenitis Suppurativa (HS)

Treatment status: ☐ New to therapy ☐ Other: ______________________ If, HS, Hurley Stage: ______________

☐ Continuation of therapy, start date: ______/______/________ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in Weight: ______ ☐ kg ☐ lb

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/______/_________ BSA affected: ________________ %

Allergies: ☐ NKDA ☐ Other: ______________________

Prior therapy, treatment dates, and reason for discontinuation: ______________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Otezla (apremilast)	☐ Starter Pack: 55 tablets	Initial dose: Take as directed per package instructions	28 days (1 pack)	0
	☐ 30 mg tablet	Maintenance dose: Take 1 tab PO twice a day	☐ 30 days ☐ 90 days	_____
☐ Siliq (brodalumab)	210 mg/1.5 mL prefilled syringe (PFS)	Initial Dose: ☐ Inject 210 mg SC on days 1 and 8	2 doses	0
		Maintenance Dose: ☐ Inject 210 mg SC every other week starting on day 15	☐ 28 days ☐ 84 days	______
☐ Simponi (golimumab)	☐ 50 mg/mL auto-injector ☐ 50 mg/mL PFS	Inject 50 mg SC once monthly	☐ 30 days ☐ 90 days	_______
☐ Skyrizi (risankizumab)	☐ 150 mg/mL auto-injector ☐ 150 mg/mL PFS	Initial Dose: ☐ Inject 150 mg SC on day 1	1 dose	0
		Maintenance Dose: ☐ Inject 150 mg SC every 12 weeks starting on day 29	84 days	_______
☐ Stelara (ustekinumab) Pt wt: _______	☐ 90 mg/mL PFS ☐ 45 mg/0.5 mL PFS	Initial Dose: ☐ Inject 1 dose SC on day 1	1 dose	0
		Maintenance Dose: ☐ Inject 1 dose SC every 12 weeks starting on day 29	84 days	_______

Prescriber Information [Ship to prescriber: Never Always First fill only Appointment date: ___/___/_____

Name: ______________________ DEA# ____________________ NPI # ______________________

Supervising Physician: Not Applicable ______________________ Supervising Physician NPI # ______________________

Address: ______________________ City: ___________________ State: ___________ Zip: _______________

Office Phone Number: (_____) _________________ Fax Number: (_____) __________ Office Contact: ______________________

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Prescriber's signature: (stamps not accepted)

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DERMATOLOGY (FORM D)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________ Patient's Last Name: ______________________

Date of Birth: _____/_____/________ Male Female Caregiver Name: ______________________

Address: ______________________ City: __________ State: ______ Zip: ________

Primary Phone Number: (_____) ______________ Alt. Phone Number: (_____) ______________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code(s): ________ Diagnosis: ☐ Psoriasis (PsO) ☐ Psoriatic Arthritis (PsA) ☐ Hidradenitis Suppurativa (HS)

Treatment status: ☐ New to therapy ☐ Other: ______________ If, HS, Hurley Stage: ________

☐ Continuation of therapy, start date: ______/______/________ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in Weight: ______ ☐ kg ☐ lb

TB test results (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: _____/______/_________ BSA affected: ________ %

Allergies: ☐ NKDA ☐ Other: ______________________

Prior therapy, treatment dates, and reason for discontinuation: ______________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Taltz (ixekizumab)	☐ 80 mg/mL auto-injector ☐ 80 mg/mL PFS	Initial Dose (PsO): ☐ Inject 160 mg SC on day 1 then 80mg every other week through week 12	6 doses	0
		Initial Dose (PsA): ☐ Inject 160 mg SC on day 1	1dose	0
		Maintenance Dose: ☐ Inject 80 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Tremfya (guselkumab)	☐ 100 mg/mL auto-injector ☐ 100 mg/mL PFS	Initial Dose: ☐ Inject 100mg SC on day 1	1 dose	0
		Maintenance Dose: ☐ Inject 100mg SC every 8 weeks starting on day 29	56 days	_______
☐ Xeljanz (tofacitinib)	☐ 5 mg tablet	Take 1 tab PO twice a day	☐ 30 days ☐ 90 days	_______
	☐ 11 mg XR tablet	Take 1 tab PO one time daily		

Prescriber Information [Ship to prescriber: Never Always First fill only Appointment date: ___/___/_____

Name: ______________________ DEA# __________ NPI # ______________

Supervising Physician: Not Applicable ______________ Supervising Physician NPI # __________

Address: ______________________ City: __________ State: ______ Zip: ________

Office Phone Number: (_____) ________ Fax Number: (_____) ______ Office Contact: ______________

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